Aim: We evaluated the use of CT in the diagnosis of acute appendicitis, comparing its efficacy to clinical diagnosis alone.
Method: A 1-year retrospective review of the medical records of all patients who underwent appendectomy was conducted.
Results: 116 patients were included. 83.6% of patients were histologically confirmed to have appendicitis. The sensitivity and positive predictive value (PPV) of CT for diagnosis of appendicitis were both 0.94. Clinical diagnosis alone had a sensitivity of 0.92 and PPV of 0.86. In terms of overall accuracy, CT and clinical diagnosis made the correct prediction in 89% and 81% of cases, respectively. Patients who underwent CT scanning were found to have a significantly longer (p=0.014) hospital length of stay.
Conclusions: CT scanning had higher sensitivity, positive predictive value and overall accuracy than clinical diagnosis alone. However, the differences were not significant. Furthermore, CT scanning was associated with a significantly longer hospital length of stay. Our findings do not support a significant added benefit of CT scanning in the routine diagnosis of appendicitis. Given its radiation exposure and high cost, its use in the diagnosis of appendicitis should be carefully considered. Nevertheless, CT scanning may be useful when clinical diagnosis is difficult.

0895: VARIABILITY IN INTERVAL FROM DIAGNOSTIC BIOPSY TO DEFINITIVE SURGICAL TREATMENT OF MALIGNANT MELANOMA IN AN IRISH TERTIARY-REFERRAL CENTRE

Michael R. Boland, Gary A. Bass, Nicola M. Hughes, Zahraa Al-Hilli, Ruth S. Prichard, Denis Evoy, Enda W. McDermott. *Department of General/Breast/Endocrine Surgery, St Vincents University Hospital, Dublin, Ireland.*
Introduction: Diagnostic excisional biopsy with follow-up definitive surgery remains the mainstay of treatment of malignant melanoma. This study sought to determine the surgical interval (S.I.) between diagnostic biopsy and definitive surgery and to elucidate factors associated with delayed definitive management.
Methods: A cohort of 110 consecutive patients who had a diagnostic biopsy and subsequent wide local excision at our institution between January 2011 and June 2012, was identified from MDT records. Patient demographics, tumour characteristics, mode of referral and surgical intervals were documented.
Results: The mean age was 60±2 (range 17 -93) years, and the male to female ratio was 1.3:1. The median duration of the S.I. was 36±3 days (Range: 6-143 days). The S.I. was longer if a dermatologist performed the diagnostic biopsy as opposed to a general surgeon (35±3 vs. 54±5 days, $p = 0.005$). The S.I. was longer for lesions involving the head/neck compared with other sites (58.2±6 vs. 40.7±3 days, $p = 0.002$). Reasons for a prolonged S.I. included referral for definitive surgery and time for preoperative staging investigations.
Conclusions: Significant variations were noted in the surgical interval. Protocolized referral pathways would decrease the SI, allowing for optimal surgical management, especially for lesions of head/neck.

0927: CAN BLOOD TEST RATIONALISATION IN EMERGENCY GENERAL SURGICAL PATIENTS BE BENEFICIAL ACROSS DIFFERENT NHS TRUSTS?

Peter Rees, Mohammed Ashrafi, Komal Patel, Jonathan Heath. *Blackpool Victoria Hospital, Blackpool, UK.*
Aim: A recent audit at a district general hospital identified that the introduction of guidelines could lead to a rationalisation of blood tests performed and significant savings. This study aimed to identify if this guideline could be successfully implemented at other trusts with similarly beneficial outcomes.
Method: All general surgical emergency admissions over 1 week were identified and prospectively analysed. Data collected included presenting complaint and blood tests on admission. A previously described guideline was applied and comparison made between predicted and actual blood tests performed.
Results: Of the 59 patients (31 female, 28 male), 15/59 (25%) were outside the remit of the proposed guideline. Only a minority adhered to the proposed guideline. CRP and amylase (26/43 and 26/41, performed vs recommended) were frequently missed, while an excess of coagulation screens were performed (23/3, performed vs recommended). Strict adherence to the guideline would have resulted in a saving of £1.93 per patient.
Conclusion: Inappropriate blood test ordering is widespread throughout the NHS. It is possible to implement a simple guideline, that would improve patient care and result in huge cost savings, across many trusts.

0940: CHANGES IN SURGICAL HANDOVER AND SCOPE FOR FUTURE IMPROVEMENT

Emma Blower, Teresa MacCarrick, Helen Forster, Paul Sutton, Dale Vimalachandran. *Countess of Chester Hospital, Chester, UK.*
Aims: Compliance with working time regulations in surgical practice has resulted in an increased number of clinicians caring for patients and subsequent handovers. In 2007, the Royal College of Surgeons produced guidelines on the minimum data-set for 'Safe Handover'. This audit examined compliance with these guidelines before and after adopting a more detailed handover 'template' with the intention of improving handover quality and safety.
Methods: Pre-existing surgical 'take' electronic handover sheets were reviewed daily for two weeks to assess compliance. A new proforma was introduced, training given and concordance re-audited. Chi-squared analysis was performed.
Results: In cycles 1 and 2, 118 and 114 patients respectively were audited. Name and responsible consultant were recorded in all cases. Age (52%,85%,p=<0.01), location (77%,95%,p=<0.01), admission date (0%,39%,p=<0.01), medical history (82%,94%,p=0.01), diagnosis (55%,93%,p=<0.01) and management (81%,97%,p=<0.01) showed a statistically significant improvement with the new proforma. Presenting complaint (93%,98%) and investigation (90%,90%) data remained good. Review frequency (5%,11%) and outstanding tasks (21%,27%) were poorly documented.
Conclusions: Significant improvement was seen in the amount of information handed-over following the introduction of the new proforma with likely positive implications on patient safety and standard of care. However, there is still further room for improvement, possibly aided by training.

0962: IS THE OPEN SURGICAL TECHNIQUE OF PERITONEAL DIALYSIS CATHETER INSERTION DATED AND TO BE DISCONTINUED?

Reena Shah, Anusha Edwards, Patrick Gordon. *North Bristol NHS Trust, Bristol, UK.*
Peritoneal dialysis (PD) is an effective form of treatment used in advanced chronic kidney disease. Several surgical techniques are employed for PD catheter insertion with literature suggesting that laparoscopic insertion is preferential over the open technique due to lower complication rates and increased patency.
We retrospectively compared our practice using the open surgical technique for PD catheter insertion against the consensus guidelines. We searched theatre records and the renal data system, over a 2-year period, looking at complication rates, 1-year patency and operative time.
Of the 68 PD catheters inserted, there were no incidences of bowel perforation, leak or haemorrhage; 2.9% developed an exit site infection, 1.5% developed peritonitis and 7.3% developed functional problems. Our one-year patency was 84.9% and mean operative time was 43 minutes with an average one night length of stay.
This study has shown that the open approach is safe and compliant with consensus guidelines for best-demonstrated practices. On review of the literature we have illustrated comparable complication rates, 1-year patency, operative time and length of stay between the open and laparoscopic techniques. This open procedure provides training opportunities in abdominal access for junior surgeons and is a more cost-effective option to the laparoscopic alternative.

1114: SURGICAL WEEKEND HANDOVER: A STRUCTURED TOOL WITH 6 STANDARDS FOR PATIENT CARE

Ruth Richardson, Luke Meleagros. *North Middlesex Hospital, London, UK.*
Aims: To assess and improve the quality of clinical handover of surgical patients to the weekend team according to 6 criteria derived from WHO, BMA and RCS guidance.
Methods: Phase 1-An audit of patient notes looked for evidence of compliance with our 6 criteria. Phase 2-An A5-sized sticker was designed as a proforma to be attached in patient notes before the weekend. Phase 3-A second audit cycle re-evaluated handover practises. The 6 standards were: 1) A clearly identifiable handover 2) The patient's consultant 3) Patient background information 4) Current clinical issues 5) Weekend management plan 6) Weekend tasks for the on-call team.
Results: The first cycle of the audit showed that compliance with each of the 6 criteria ranged from 9-66%. The second cycle, following the